Institutional Care for Elders in Rural China

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Abstract:
The long-term care (LTC) literature has been generally associated with industrialized countries. However, LTC needs are increasing in the developing world at a rate that far exceeds than experienced by industrialized countries. Using China as a case study, the purpose of this report is to provide an example of an emerging institutional care system for rural elders in a rapidly developing country. It covers two major domains of the system: service delivery and financing. The report presents several main issues involved in the development of institutional care for elders and discusses relevant policy implications.
KEYWORDS: Institutional care, China, elders, policy

Article:

Introduction

The long-term care literature and the need for long-term care (LTC) have been generally associated with industrialized countries. Whereas family support is a predominant pattern of care in many developing countries, development of other mechanisms for LTC is a growing need. What is not widely realized is that LTC needs are increasing in the developing world at a rate that far exceeds that experienced by industrialized countries. The recent report from the World Health Organization (WHO) indicated that the need for LTC is due to (1) the increase in prevalence of long-term disability occasioned by an increase in number and percentage of older adults in developing countries, and (2) the change in the ability of the informal support system to take care of frail elders (Brodsky, Habib, & Hirschfeld, 2003). Many developing countries are at the initial stage of developing LTC services (Brodsky, Habib, & Hirschfeld, 2003). For example, in Sri Lanka, the government has started to play a role, albeit minimally, in the provision of institutional LTC (Abeykoon, 2003). In a number of countries, mainly nongovernmental organizations—religious institutes in particular, together with a network of volunteers—have addressed the rapid process of aging and the increasing need for LTC (WHO, 2000).

While stages of economic development are quite different and there is much variation in cultural values and norms toward caring for frail elders, the experiences of developed countries can provide lessons and guidance in establishing and maintaining of LTC systems. Although institutional care systems for elders in developed countries vary in type and quality of care, the initial stage of development of LTC usually involves two systems: a social welfare system in which the government supports indigent elders and a volunteer or private initiative to support elders. For example, in the United States, prior to the Great Depression in 1929, poor houses or almshouses were the only forms of institutional care available. Public welfare revolved around the principles of the post-1834 English poor laws, which included local financial responsibility and exclusive reliance on institutional "indoor relief" for the indigent. In the American system, by the early Twentieth Century, the states generally assumed responsibility for institutions housing the mentally ill and the blind; the other categories of "deserving poor" (the retarded, the chronically ill, and the feeble elderly) remained wards of the counties or municipalities, housed in country "homes" or farms at local expense. In the latter years of the Nineteenth Century, the forerunners of modern voluntary nursing homes were largely the product of immigrant self-help organizations (Vladeck, 1980). In Germany until the early 1960s, institutional care, mostly provided in substandard facilities, was available for a small percentage of old people who tended to be poor and without

any informal source of help. Formal LTC was a branch of the voluntary welfare sector, organized mainly by church communities and welfare organizations (Heinernann-Knoch, 1994).

Given the fact that little information on LTC in developing countries is available in the gerontological literature, there is a great deal of uncertainty regarding whether the extent of what is now occurring within institutional care for elders in developing countries mirrors the progression as documented in developed countries. Developing countries represent different levels of economic development and different stages in demographic and epidemiological transition; however, they are confronting some similar issues, such as an increasing number of frail elders, erosion of family care systems, limited economic resources, and unavailability of outside LTC ser-vices. A major challenge is how to develop LTC services and programs to serve frail elders. In developing countries, a large proportion of elders with lower income reside in rural areas. For that reason, this study focuses on the current arrangement of LTC in rural China. Although its generalizability may be limited, we hope that this article will contribute to the emerging international body of knowledge on LTC for elders and encourage similar studies in other developing countries with a view to developing a generalizable pattern of policies and procedures. The purpose of the study is thus to provide an example of an emerging institutional care system for rural elders in a rapidly developing country.

Background

Developing LTC systems for the elderly has become an increasingly urgent policy issue in China, especially in the rural areas. Based on the Fifth National Census in the year 2000, the number of Chinese elders is increasing dramatically, the majority of whom (65.83%) currently resides in rural areas. The overall rural elderly population is 85.58 million (Jiang, 2005). Within this aging population, the subgroup of elders aged 80 and above, also known as the "oldest old," is the fastest growing group. 'The oldest old grew to approximately 11.5 million individuals in the year 2000 and accounted for nearly 9% of all elders aged 60 years and older (130 million) (National Bureau of Statistics of China, 2002). By the year 2050, China's population aged 60 years and older is estimated to swell to more than 400 million people, representing approximately 25% of the total population. Roughly 99 million people in China will be among the oldest old and will constitute 22.7% of all elders in China (Zeng etal., 2002). Increasing numbers of the oldest old create a growing demand on long-term care. The oldest old are more likely to develop some functional disabilities and will need to be taken care of sometime during their advanced age.

The increase of social mobility and an increase in the oldest old population have resulted in difficulty fulfilling traditional filial duties. In addi-tion, due to smaller families with fewer children, the availability of family members to provide care and support to elderly parents will most likely continue to decrease (Bartlett & Phillips, 1997). The current situation in China is similar to that in many developing countries: Care for elders is almost solely the responsibility of family members, relatives, or other informal (unpaid) caregivers. However, the family support system for elders is becoming a challenging issue, especially as an increasing number of young people are moving to cities and leaving their elders behind. Today, potential job opportunities, higher incomes, and living standards have induced many workers to leave their homes for the cities. Because the urban housing registration system has become more relaxed and now allows migrant workers to apply for temporary registration, urban areas are experiencing rapid in-migration. According to the Fifth Chinese Census, in the year 2000, there were 3.87 million migrants in Shanghai alone, and 73.4% (2.84 million) of them had entered the labor force. Countrywide, there were over 121 million migrants across China (National Bureau of Statistics of China, 2002). As a result, the informal "system" of caring for the old is facing a great challenge. One of our studies suggests that people prefer family support (Wu & Mao, 2005); however, many are concerned that no one will be available to take care of them. In addition, they are also concerned about the burdens of paying for daily living needs and health care. According to a national survey conducted by the Ministry of Civil Affairs, 80% of the farmers rated "care for the old age" as the issue that needs the most urgent attention (Yao, Xu, Zeng, & Fang, 1997).

Despite the increasing challenge of caring for current and future elders, family support for frail elders will continue to be the predominant care pattern in China. As indicated in our earlier study, it is critical to develop community-based LTC services and programs to help informal caregivers to support their elders (Wu, Carter, Goins, & Cheng, 2005). In the meantime, the development of institutional care for elders also needs special attention since it is a vital supplement to the LTC system, and it provides the last resort for individuals who need the most care but who do not have appropriate care available in the community. This article aims to provide a comprehensive view of the current status of institutional care for elders in rural China. Service delivery and financing are global concerns in the development of LTC systems. In what follows, we focus on these issues with respect to the social welfare system that operates welfare institutes and homes for the aged, its future development, and policy implications.

Methods

A multilevel approach to data collection was used in this project. In addition to conducting interviews with policymakers and scholars in Beijing, all other field trips were conducted in Hubei and Shanghai. Hubei province is located in an inland area of China. Its economy reflects the national average. Long-term care development in this area reflects the most common and typical arrangement in China. Shanghai is one of the most developed areas in China. Its LTC system is far more developed than the rest of the rural areas in China. By illustrating the development of LTC facilities in these areas, this study will provide an overview of the LTC arrangement in rural China.

This study was conducted between June 2004 and January 2006. The data collection included the following: (1) an examination of available policy documents and literature; (2) interviews with policy-makers and governmental officials. The research team met with 15 officials from the health departments and civil affairs bureaus at national, provincial, and local levels. These are the main government agencies responsible for the planning, provision, and oversight of LTC and related facilities operating in China at national and local levels; (3) interviews with 12 scholars and experts who have conducted relevant research and/or are familiar with the LTC system in rural China; and (4) field visits to 12 homes for the aged and welfare institutes in Hubei Province and Shanghai (see Table 1). Semi-structured in-depth interviews were conducted among administrators and elderly residents during these visits.

Findings

Current LTC Service Delivery System in Rural China

Currently, China has two systems that provide institutional care for elders: (1) the social welfare system, which is run by departments of civil affairs at various levels and operates welfare institutes, homes for the aged, and veteran care facilities; and (2) the medical care system, which is run by the department of health, manages geriatric hospitals, nursing facilities, rehabilitation wards, and mental health hospitals for demented elders. These two systems have separate funding mechanisms and policies, thus creating different segments for LTC.

Geriatric hospitals and rehabilitation wards in general hospitals constitute the LTC service system in the medical sector. These services have started to emerge in urban areas; however, very few have appeared in rural areas. Most of these hospitals are run and managed by the local departments of health. Many medical expenses are covered by medical insurance, which rural residents do not have.

Veteran care facilities provide LTC services, but only a few of them exist. The authors estimate that 802 veteran institutes care for almost 20,000 childless, retired veteran soldiers. For example, Hubei Provincial Veteran Hospital, one major veteran hospital in Hubei, provides LTC for veterans who are functionally disabled, many of whom are elders.

In terms of institutional care, welfare institutes and homes for the aged have played the most important role in providing LTC for rural elders. These organizations have undergone rapid changes in recent years. In addition, some private, nonprofit LTC facilities have been established to supplement public facilities.

TABLE 1.
Summary of the institutes visited

	Wubao versus Other Elders	Occupancy	Government Subsidies	Other Income
Sun He Township Welfare Institute for Elders	78 vs. 0	80%	1. Given the building and land 2. 100 yuan monthly per/resident	1. Plant vegetables and raise pigs
Zhong Yi Township Welfare Institute for Elders	35 vs. 0	85%	1. Give the building and land 2. 100 yuan monthly per wubao resident	1. Plant vegetables and raise pigs 2. Donations from outside
Hong Shan Residential Facility for Elders	14 vs. 40	95%	1. Give the building 2. 150 yuan monthly per wubao resident	1. Charge monthly fees for non-wubao elders (450 to 650 yuan) 2. Township factory's income
Yang Ping Township Welfare Institute	47 vs. 0	100%	1. Give the building and land 2. 100 yuan monthly per wubao resident 3. Pay two staff's salary (total of 8,400 yuan)	1. Plant vegetables and raise pigs
Jiu Xian Township Welfare Institute	72 vs. 0	100%	1. Give the building and land 2. 100 yuan monthly per wubao resident 3. Pay some staff's salary	1. Plant vegetables and raise pigs
Yu Xi Welfare Institute	45 vs. 0	50%	1. Give the building and land 2. 164 yuan monthly per wubao resident 3. Pay some staff's salary	1. Plant vegetables and raise pigs 2. Lease spare rooms to outside
Shanghai Song Jiang Social Welfare Institute*	0 vs. 223	98%	1. Government built new facilities 2. Government allocated 200,000 yuan each year	1. Charge monthly fee from residents (690 to 2,280 yuan) 2. Lease some office space 3. Donations
Shanghai No. 4 Social Welfare Institute	0 vs. 330	100%	1. Government built facilities 2. Government funded operation	1. Charge monthly fee from residents
Shanghai She Shan Township Home for the Aged	60 vs. 70	52%	1. Government built facilities 2. Government allocated 630,000 yuan yearly (including wubao elders' months fees and staff salary)	1. Charge monthly fee from non-wubao residents (420 to 880 yuan)
Chong Ming Xing He Township Home for the Aged	23 vs. 153	100%	1. Allocate buildings and land 2. 234 yuan monthly per wubao resident	1. Charge monthly fee from non-wubao residents (320 to 850 yuan) 2. Plant vegetables and raise pigs
Chong Ming Xing Ming Township Home for the Aged	24 vs. 52	90%	1. Allocate buildings and land 2. Government allocated 80,000 yuan yearly 3. 234 yuan monthly per wubao resident	1. Charge monthly fee from non-wubao residents (320 to 850 yuan) 2. Plant vegetables and raise pigs
Chong Ming Cheng Qiao Township Home for the Aged	16 vs. 104	95%	1. Government built facilities 2. 234 yuan monthly per wubao resident	1. Charge monthly fee from non-wubao residents (350 to 900 yuan)

Note: Monthly fee for non-wubao residents varies, based on number of individuals sharing one room and the level of care needed. 'Although located in a rural area, most residents are from urban areas.

Number and Percentage of Elders in Rural Institutions

In rural areas of China, welfare institutes have traditionally been the place for institutional care for elders, with the exception of veteran hospitals that accept disabled and/or retired veterans. 'These welfare institutes (which can be called either "homes for the aged" or "welfare institutes") only accept *wubao* elders and orphans; for our study purpose, we focus on wubao elders. Wubao elders are those eligible for a government-funded welfare system called the "Five Guarantee System" (in Chinese, wubao means "five guarantees"), This support system guarantees that eligible elders (i.e., wubao elders) receive the five basics of life: food, clothing, housing, medical care, and burial after death. Eligibility for entry into this system requires (1) no ability to work, (2) no income source, and (3) no children or other people with a legal responsibility for support and care (those eligible are called "Three No") (Ministry of Civil Affairs, 2004). Overall, close to 3 million wubao (or "Three No") elders live in rural China, representing approximately 3,4% of the elders aged 60 and above (Li, 2004).

In recent years, due to the economic reform taking place in China, the government has not fully funded many welfare institutes. In some areas near larger metropolitan areas, an increasing number of welfare institutes/ homes for the aged have started to accept non-wubao elders. Some facilities have changed their names to

"residential care for elders" or "elderly housing/apartments." However, the functions are the same as those at the older homes for the aged or welfare institutes.

The main facilities for institutional care for elders, however, are still township welfare institutes. At the end of 2002, approximately 35,000 institutes had 967,000 available beds and housed 689,000 elders (Zhang, Su, Li, & Xing, 2005). Approximately 30,000 of these institutes housed wubao elders. The total number of wubao elders in institutions was 601,000, which constitutes 20% of approximately 3 million wubao elders in rural areas. The remainder of wubao elders resided in the community (Li, 2004).

The Ministry of Civil Affairs announced on June 8, 2001, that the Xing Guang Project would address the challenges of an aging society. The ministry allocated 20% of social welfare lottery money for this project. Goals of the project state that departments of civil affairs at the central and local government levels would support the building of elderly welfare residential care and senior activity facilities in urban communities and the building of township residential care facilities for elders in rural areas in the next three years (Ministry of Civil Affairs, 2001). The number of beds and institutionalized elders has increased since 2002. At the end of 2004, the number of beds was 1.06 million, and the number of institutionalized individuals was 846,014 (Ministry of Civil Affairs, 2005). Between 2002 and 2004, the number of beds increased 9.6%, and the number of institutionalized individuals increased 23%. In the past several years, central and local governments have demanded more beds every year, under the assumption that more elders will need to be institutionalized as time progresses. In addition, there has been a recent push to encourage wubao elders to enter institutions.

Community-dwelling wubao elders tradition-ally have relied on what was once the village's collective economy. How-ever, economic reform has changed the financing system to generate revenue from the local source; this revenue goes to government offices at various levels. The revenue to support community-dwelling wubao elders comes from the local village government and is distributed by the local civil affairs bureau. Some government officials and scholars in Hubei think the funding source from local revenue to support community-dwelling wubao elders is not reliable because it relies on the local economy and because funding might not always be allocated appropriately in terms of timing and amount. On the other hand, the funding for institutions comes from provincial government revenues and is more reliable. In addition, whereas community-dwelling wubao elders have been traditionally dependent on neighbors' support, that neighborhood support system becomes less stable with an increasingly migrant population (Li, 2004; Mr. Liu, Director of the Social Welfare Office at Hubei Civil Affairs Bureau, personal communication, June 7, 2004). Since 2003, as part of this national Xing Guang Project, Hubei province has launched a project called Fu Xin Project. This project invests funding to renovate and expand the existing welfare institutes. One goal is to increase greatly the admission of wubao elders.

At the end of 2002, there were 44,000 wubao elders in the institutions, which was 21% of all wubao elders in the province. By spring 2004, the number of institutionalized wubao elders had increased to 105,000, which represented 50% of all wubao elders (Mr. Liu, Director of the Social Welfare Office at Hubei Civil Affairs Bureau, personal communication, June 7, 2004).

At the end of 2004, institutional beds were available for 0.9% of elders aged 60 and above. In rural areas, the percentage was 1.24%. In more developed rural areas, a greater number of institutional beds are available than in underdeveloped rural areas. For example, in 2004, the percentage of beds available in rural Shanghai areas was 2.7% of elders aged 60 and above, 1.46% higher than the national average, and also more than 0.7% higher than in urban Shanghai areas. In the nation, the percentage of institutionalized elders is approximately 1% in rural areas, of which non-wubao elders are only around 0.4%. Given the fact that wubao elders are the main component of the institutionalized population and many of them do not have a functional impairment (see the section on admission criteria for further discussion), the percentage of elders with functional limitations living in institutions is even lower.

An overwhelming majority of elders with disabilities resides in the community. Based on the estimates from the Third National Health Survey conducted by the Ministry of Health in 2003-2004, the number of individuals

aged 65 and older in rural China who had long-term functional impairment was 8.52 million, which constituted 9% of the population aged 65 and older in rural China (Third National Health Survey, 2005). Some studies conducted locally suggested a similar percentage of disabled elders. A study conducted among 3,745 persons aged 65 and older in Shanghai (including both rural and urban areas) indicated that the prevalence of disability was 8.3% (Zhang etal., 2001). In a survey con-ducted in Hubei in the late 1990s among the 97,000 elderly respondents age 60 arid above, 10.7% were ill and dependent on others for daily living (Fu & Xue, 2003).

Number of Institutions for Elders and Sizes of Institutions

The number of beds in each institution varies a great deal. The Ministry of Civil Affairs requires each township to have one welfare institute. Currently, 90% of the townships have at least one. These welfare institutes are responsible for wubao elders in the affiliated villages and nearby areas. Typically, the number of beds in each institute ranges from 30 to 100. Institutions that have only wubao elders are often small; some still have space to accept more elders. In suburban areas of big cities or in east coast areas where the local economy is more developed, an increasing number of township welfare institutes have started to accept non-wubao elders. Room occupancy varies from one person per room to up to four per-sons per room. During the site visits to institutes that only accept wubao elders, there was typically either one person per room or two persons per room. For those that accept non-wubao elders, room-sharing varied from one person per room to multiple persons per room, depending on the admission fees.

Admission and Exclusion Criteria for Institutionalization

For most of the current welfare institutes in rural areas, the criteria for admission are "Three No" elders (see description in *Number and Percent-age of Elders in Rural Institutions).* Village committees identify these elders, and staff from local civil affairs bureaus confirms these elders to be eligible as "Three No" elders (wubao elders). Once they are identified, they are eligible to be admitted to the homes for the aged anytime (no criteria for age and disability). Although one criterion for wubao elders is no ability to work, the criterion could be loosely defined. In reality, many wubao elders are still working either in the field or doing household work in each institution. Based on a survey conducted among 543 wubao elders in some welfare institutes of rural Hubei, 35.36% reported working frequently in the institutions, and 26.34% reported working sometimes (Mao & Li, 2006).

Not all elders can be admitted to an institution. The three most common exclusion criteria are (1) infectious disease(s), (2) mental illness (including dementia), and (3) functional dependency (semi-bedridden or bedridden). For non-wubao elders, before admission to the institute, each one has to fill out a form related to his or her status and sign a contract. The contract indicates that these elders will be discharged from the institute if they develop any of these conditions. 'These elders have to be taken care of at home or in a mental hospital or a regular hospital, which few rural farmers can do because of associated costs. When we asked several administrators why they exclude dementia patients since it is such a common disease among elders, they replied that they do not have the capability to care for them. One common symptom of dementia is wandering. They do not want to take responsibility for their safety if these elders wander off and get lost since the staff does not have time to supervise patients around the clock. Another common symptom of dementia is suspicion caused by memory loss, which could cause conflicts among residents when dementia patients accuse others of stealing. When asked about wubao elders who don't have any other places to accept them, administrators consistently said that they had to lock the patient in a room if that per-son had the habit of wandering off. Another common practice in cases of conflict between a dementia patient and his/her roommate(s) is to change roommates.

Shanghai Song Jiang Social Welfare Institute is one of the state-of-the-art facilities in Shanghai. Although it is located in a rural county, most of the residents come from Shanghai urban areas who can afford high admission fees. At a county-level institute, the Song Jiang Social Welfare Institute receives subsidies from the county civil affairs bureau, but it no longer accepts wubao elders. The institute has nursing wards, and medical and nursing staffs for individuals with different levels of functional limitation. It also has residential sectors for elders with no functional limitations. However, there are very few facilities such as this in China.

A recent report indicated that more than 90% of the elder care facilities in Beijing do not accept dependent elders (Yi, 2005). She Shan is a recently developed wealthy town located in Song Jiang County, Shanghai. Shanghai She Shan Township Home for the Aged is a recently renovated facility which the first author (B. W.) visited, where she was told that no single resident was bedridden in the facility because they don't admit any non-wubao elders who are semi-dependent or dependent. The administrators are worried that they don't have the personnel and facility to care for them. In general, the percentage of dependent residents who are bedridden or semi-bedridden is usually very low (less than 10%) in those facilities that do accept them.

Financing of LTC

Sources of Funding. An overwhelming majority of the elder care facilities in rural areas is government-sponsored; this is especially true in rural inland areas. At the end of 2004, 36,890 of the elder care facilities were government or collectively sponsored; this number is 96% of all institutes in rural China. Most are township welfare institutes. The local civil affairs bureau and township committees support these institutes by providing buildings, office space, land, and key administrative staff. In addition, the government allocates funding to institutes that admit wubao elders. In 2004, in developed rural areas (i.e., the East Coast areas), funding provided by local governments to welfare institutes ranged from 1,800 to 2,500 *yuan* annually for each wubao resident. (In early 2005, one dollar was equivalent to 8.25 yuan.) In mid-regions of China, the fee is 1,200 to 1,500 yuan, and in western areas the fee ranges from 900 to 1,100 yuan (Q.C. Yan, Deputy Director of China's National Committee on Aging, personal communication, December 20, 2005). This amount covers elderly residents' food, housing, clothing, medical expenses, and burial, and it supplements staff salaries. In addition, the government also gives institutes land to help them cover their daily expenses. Institutes organize staff and elderly residents to raise pigs and plant vegetables to support themselves. As indicated earlier, most of the elderly residents are not functionally disabled and are able to work in the field. For many institutes, selling pork and vegetables at the market is a way to earn additional money.

Institutes that do not have land depend on admission fees from non-wubao elders. In most cases, these institutes are located near cities. In the Hong Shan Residential Facility for Elders in Hubei, the admission fee ranges from 450 to 650 yuan for non-wubao elders, which is at least 300 yuan higher than the fee paid by wubao elders. In Chong Ming Cheng Qiao Township Home for the Aged in Shanghai, the admission fees for non-wubao elders range from 350 to 900 yuan, while for the wubao elders the fees are 234 yuan. The fees vary, based on the level of care provided and housing conditions.

Privately run care facilities have developed in some rural areas in the past decade. In 2004, among the 224 total elder care facilities in rural areas or formerly designated rural areas near Shanghai, 42% are non-government-sponsored. These privately run organizations rely almost exclusively on admission fees from residents, but they are not required to accept or to subsidize wubao elders. In general, compared to government-sponsored institutes, the fees are higher but the infrastructure is poorer. Some or these private elder care institutes rent buildings or renovate older structures. The Shanghai Civil Affairs Bureau has encouraged the development of private non-government-sponsored elder care facilities by providing a one-time subsidy of 5,000 yuan per bed (F. Zhang, deputy director of Office of Social Welfare at Shanghai Civil Affairs Bureau, personal communication, January 9, 2006). However, a large percentage of the privately run institutes have lost money on this type of business. In a market-driven economy, there is unequal competition between government-sponsored and non-government-sponsored institutes.

Funding from Non-Wubao Elders and/or Their Family Members. Non-wubao elders have to pay admission fees to enter a care facility. In most cases, family members (i.e., adult children) are responsible for this expense. However, some elders are now able to pay their own expenses. Rapid economic growth has been occurring in rural Shanghai, and rural Shanghai areas have been in the process of transition into suburban and urban areas. As a result, many farmers whose lands have been taken by companies or the government are relocating to different areas. During this process, some elders are using these relocation fees to pay for their admission to care facilities instead of buying homes.

Medical Care in LTC Institutes

China's health care system is bifurcated. While most urban employees have employer-sponsored health insurance, rural farmers do not have any type of health insurance. Prior to the 1980s, in rural areas the cornerstone of the health care system was the commune. The commune owned the land, organized its cultivation, distributed its harvest, and supplied social services, including health care provided through the Cooperative Medical System. The Cooperative Medical System operated village and township health centers that were staffed mostly by practitioners who had only basic health care training-the so-called barefoot doctors. In the early 1980s, in its effort to privatize its economy and reduce the role of the central government in China's regional and local affairs, the government suddenly and completely dismantled communes to privatize the agricultural economy. A side effect was to rip apart the health care safety net for most of rural China.

Without the Cooperative Medical System. Chinese peasants had no way to pay for health care; 900 million rural, mostly poor farmers became, in effect, uninsured overnight (Blumenthal & Hsiao, 2005). While most clinics and hospitals are still government-owned, only limited funds are allocated to support health care professionals. To a large extent, the barefoot doctors became unemployed and were forced to become private health care practitioners who paid themselves a "salary" by selling prescription drugs.

To provide basic health care for rural farmers, a New Collective Medical Insurance was developed in 2002; it is designed to cover some major hospital expenses. In Hubei province, the New Collective Medical Insurance covers 40% of the hospital expenses and has an annual cap of 5,000 yuan for each individual. The annual premium for *each* participant was 30 yuan. Individuals and local and central governments each contribute 10-yuan premium to the account. Starting in 2006, local and central governments have increased their contributions to this insurance from 10 to 20 yuan, with a total government contribution of 40 yuan to each individual's account. Farmers still need to pay all outpatient expenses and drug costs. In rural Hubei, approximately 20% of the population has New Collective Medical Insurance (Wu, Mao, & Liu, 2006). Therefore, medical care is one of the most serious issues facing rural elders. By its definition, wubao elders' medical costs are covered by each institute, although the medical care they receive can be minimal. Health care-seeking behavior for elders often follows a generalized pattern: from a small in-house "clinic" to a village clinic, and then to a township hospital. In each welfare institute or home for the aged, there is a small clinic that can dispense a few non-prescription drugs. If an elder is sick, the staff will give some medications to the person. If an elder has a more serious illness, with the administrator's permission, a village doctor will be called from the village clinic to come to the site to see a patient. Some welfare institutes have reached an agreement with the village clinic, and the village doctors will schedule regular visits to the institute, in many cases once a month, to see patients. An elder with a more severe acute illness will be sent to a township hospital. During our site visits, administrators stated that most elders' illnesses are treated by non-prescription drugs. In Jiu Xian Welfare Institute, of 72 elderly residents, only about 30% of them were seen by a village doctor and only two were hospitalized last year. Most administrators interviewed said that they were lucky that, overall, the residents were healthy, and few had been admitted to hospitals in the past year. Otherwise, they would not be able to afford the medical expenses for these elderly residents. Institutionalized elders are generally covered by the New Collective Medical Insurance. However, this insurance only covers 40% of hospitalization expenses; the remaining 60% is split between the insurance and the patient.

Wubao elders' chronic conditions are most likely to be neglected in institutions. During the site visits, several elderly residents said they had chronic illnesses, but either they don't want to seek treatments or the staff refused to take them to see a doctor outside the institution.

Local economy has much to do with medical expenses for wubao elders. In Shanghai rural areas, the local government will cover most medical expenses of hospitalized wubao elders since the economy in these areas is relatively more stable than in Hubei.

Non-wubao rural elders must purchase their own drugs in the institute if they become ill. If elders need to go to outside clinics or hospitals, institute staff will contact their families and get approval to do so. Family members are responsible for paying the medical expenses.

Regulation for Institutions

In rural Shanghai, four different care levels have been established in elder care institutes: (I) The 3rd level of care is for those living independently and who do not need help from others; (2) the 2nd level is for those who either (a) are aged 80 or above, or (b) rely on a cane or wheel chair and need help from others; (3) the 1st level is for those who (a) are aged 90 or above, (b) need other people's help to perform daily activities, or (c) have mild cognitive impairment; and (4) a special care level is for individuals who (a) are completely dependent on care from other people, or (b) have moderate cognitive impairment or beyond (Shanghai Civil Affairs Bureau, 2004). Admission fees are different depending on the level of care the institute will provide for each individual. While these criteria have been widely introduced in rural Shanghai, many institutes admit only individuals within the 2nd and 3rd levels. In Hubei, these kinds of regulations and standards have never been implemented. In welfare institutes in Hubei, care for wubao elders largely relies on wubao elders themselves. The site visits revealed that one principle of assigning living arrangements in institutes is for the younger old to help and care for the older old, and the healthier ones to care for those who are sick. The staff takes responsibility for wubao elders who are bedridden.

Discussion

The findings from this study reflect issues related to institutional care for elders that the United States and other developed countries have experienced in the past and some with which they are still struggling. In the past century, institutional care for elders in developed countries has evolved from residential care facilities for indigent elders (e.g., poor houses in the United States) to modern institutional care facilities that care for a range of elders with mental and functional disabilities (i.e., nursing homes and assisted living facilities). China is working towards developing a modern concept of institutional care facilities, particularly in wealthy developed areas. This study provides some policy considerations and practical implications for the development of institutional care for elders in China. Several issues are worth discussing.

Government Role and Public Support

Different from many developing countries, the Chinese government (instead of religious and charitable organizations) has been a major source of support for institutional care for poor elders in the initial stage of the development of LTC in China. In the future, it is most likely that the government will continue to play a leading role in designing, developing, and establishing strategies and policies for institutional care. However, lessons from other countries suggest that the government needs to set up policies and create an environment that will encourage private and non-profit organizations to establish institutional care facilities.

A call to reform the government funding mechanism is in place as private institutes in China begin to emerge. Currently, there is unequal competition between government-sponsored welfare institutes and those that are private, non—government-sponsored. One major difference is that most government-sponsored welfare institutes are required to accept wubao elders. In the future, as in many developed countries, public funding needs to go directly to each eligible individual (e.g., wubao elders), and therefore institutes can be indirectly funded by accepting these elders. In this case, a more equitable market competition will be created in the LTC service field.

Currently, government funding for institutional care is invested in social welfare institute or homes for the aged, with emphasis on wubao elders. The premise of family support for the majority of frail non-wubao elders is increasingly facing challenges (e.g., a changing cultural value of filial responsibility, changing population structure, increasing mobility, and a widening gap between rich and poor). There is a need to increase government funding to support institutional care for poor and frail elders. Since 2003, Shanghai has subsidized community-based LTC services for very poor elders, although the funding is quite limited, and the scope of support is minimal (Wu et al., 2005a). With the continued growth of China's economy, it is

likely that more public funding will be available to expand the support of institutional care for low-income non-wubao frail elders; nonetheless, if based on the local economy, the scope of support can vary a great deal across regions.

Health Evaluations

In addition to income eligibility, standard health assessments need to be implemented. The study found no standard assessments of elders' health status and needs for services in institutional care settings in rural areas. In rural areas, this measure is necessary to determine at what stage wubao elders and non-wubao elders should be admitted to elder care facilities. Given that most elder care facilities are government-sponsored, standard health measures should be the primary criterion for allocating public funds and ensuring the provision of appropriate ser-vices to meet the needs of frail elders. Funding also needs to be allocated to individuals with various levels of physical and mental disabilities. Standard guidelines need to be established for elders to enter institutions. Additionally, a classification system for residents is needed.

Implementation of a Quality Monitoring System

While most elder care institutes currently are publicly funded or subsidized in rural areas, an increasing number of residents in these institutes will be paying out of pocket in the future. In addition, although in limited numbers so far, expensive private institutes are being established to meet wealthy individuals' needs caused by the increasing number of middle-class individuals in China. As a result, a variety of institutional care facilities will be co-existing in the future. To date, no systematic quality control mechanism exists for this sector. It is critical for the government to design standard regulations and a quality monitoring system. Stringent quality controls, such as closer supervision and standardized quality evaluation procedures, are needed to ensure quality care. Program evaluation can be conducted by government officials, institutes, and by institution residents and their family members.

Integration of LTC with the Acute Health Care System

The integration of LTC with the acute health care system is a fundamental issue for both developed and developing countries (Brodsky etal., 2002). China is no exception. The Ministry of Civil Affairs has played a major role in providing residential care for elders. In addition, the Ministry of Health has some responsibilities for caring for long-term disabled elders in a hospital setting. These two programs are disjointed. In the United States over the past 30 years, two demonstration projects-The Program of All-Inclusive Care for the Elders (PACE) and Social Health Maintenance Organizations (SHM0s)-have used a multidisciplinary team to integrate acute medical, hospital, and LTC service delivery for assuring continuity among services to improve outcomes for frail elders (Mui, 2001; Yee, 2001). In China, some discussion has taken place at the national level on how to consolidate funding to provide more integrated services to those insured, most of whom are urban residents. Some researchers have suggested creating more multilevel and multifunctional LTC facilities to provide care (both medical and social services) for individuals with various levels of disability. Overall, as Brodsky etal. (2003) have indicated, there are a number of program components that can be integrated: finance, administrative responsibility, and organization of care, which includes gate keeping, assessment, and direct care provision. Integration can imply the unification of one or all of these components.

The development of institutional care for elders in China can benefit from the experience of developed countries, but it also must consider China's unique cultural norms and economic constraints. On the continuum of care, and with respect to the preferences of elders, we have to be aware that the choice of institutional care is the last resort. First and foremost, the goal should be to support informal caregivers in their efforts to care for elders in the community. Recommendations to accomplish this goal are as follows: (1) Funding priorities should be set to support family members, particularly in low-income families, and community-based long-term care services and programs; (2) encourage volunteer work and mutual help (Wu, Yue, Silverstein, Axelrod, Shou, & Song, 2005); (3) train family caregivers by supporting, guiding, educating, and informing the disabled and his/her family (Brodsky etal., 2003; WHO, 2000).

Development of long-term care is a complicated issue. For this study, the authors used China as a case study to stimulate more discussion and draw attention to emerging LTC systems and issues in developing countries. The

focus of this report has been delivery and financing mechanisms for institutional care for elders. We acknowledge that the workforce issue is an important component of long-term care systems; description and discussion of this issue will be the topic of another article. We also would like to point out that Shanghai and Hubei were chosen to illustrate LTC services in rural China. However, those services, while reflecting the situation in many rural areas, should not be considered representative of all areas in China.

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